Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00376-201

Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center North Chicago, Illinois

May 31, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
CSC	Construction Safety Committee
DoD	Department of Defense
ECOMS	Executive Committee of the Medical Staff
EHR	electronic health record
EOC	environment of care
facility	Captain James A. Lovell Federal Health Care Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalent
FY	fiscal year
HPC	hospice and palliative care
LIP	licensed independent practitioner
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PE	pulmonary embolism
PR	peer review
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 11, 2013.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Long-Term Home Oxygen Therapy

The facility's reported accomplishments included developing and activating the first-of-its-kind integrated VA and Department of Defense Federal Health Care Center and having two of its Lean Six Sigma performance improvement projects featured on Joint Commission Resources Quality and Safety Network.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Consistently report the results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Executive Committee of the Medical Staff. Revise the local observation bed policy to include all required elements. Reassess observation criteria and utilization when conversions from observation bed status to acute admissions are over 30 percent. Include all services in the review of electronic health record quality. Include the results of proficiency testing and the results of inspections by government or private (peer) entities in the blood usage and review process.

Environment of Care: Consistently clean patient care equipment between patient use. Ensure that gloves in all sizes and gowns are available in the therapy clinic areas.

Medication Management – Controlled Substances Inspections: Sufficiently rotate inspectors in inspection assignments, and monitor compliance. Ensure inspectors do not participate in inspections beyond their 3-year appointment expiration date, and monitor compliance.

Coordination of Care – Hospice and Palliative Care: Include a dedicated nurse, social worker, and administrative support person and a 0.25 full-time employee equivalent psychologist or other mental health provider on the Palliative Care Consult Team. Ensure that all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Nurse Staffing: Monitor the staffing methodology that was implemented in October 2012. Ensure that unit 134-3C's nurse managers reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Preventable Pulmonary Embolism: Initiate protected peer review for the identified patient, and complete any recommended review actions.

Construction Safety: Ensure that routine construction site inspections are conducted by the required Construction Safety Committee members, include all required elements, and are documented. Require that Construction Safety Committee minutes contain documentation of deficiencies identified during inspections and any follow-up actions in response to unsafe conditions and that minutes track actions to completion.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–26, for the full text of the Directors' comments.) We consider recommendation 14 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable PE
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through February 14, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the North Chicago VA Medical Center, North Chicago, Illinois,* Report No. 08-02601-131, May 20, 2009).

During this review, we presented crime awareness briefings for 110 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 450 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

First-of-Its Kind VA/DoD Federal Health Care Center

The integration of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes began in October 2003 and is now in Phase III of its development. On October 1, 2010, the Federal Health Care Center was activated. It represents the first-of-its-kind partnership between VA and DoD and was designed as a 5-year demonstration project that would focus on integration opportunities and efficiencies.

Some of the facility's integration achievements in 2012 were:

- Co-locating the Compensation and Pension Examination Program and the Integrated Disability Evaluation System. This has resulted in the facility being ranked as number one in timeliness of completing integrated disability evaluations.
- Developing an integrated, strategic dashboard to improve operational efficiency in VA and DoD clinics.
- Establishing the first fully-integrated VA/DoD dental clinic.
- Two Navy Master-at-Arms completing the VA's Police Academy and returning to provide protective services on the facility's campus. These were the first two active duty sailors to attend and graduate from VA's Law Enforcement Training Center.
- Six Navy Hospital Corpsmen completing a 26-week specialized clinical training program and working in the inpatient medical/surgical unit, intensive care unit, and emergency department.

Lean Six Sigma Projects

In August 2012, the facility was featured on Joint Commission Resources Quality and Safety Network in a presentation titled, "How Do They Do It? Meeting Top Compliance Issues." The vignette was named "Developing Your Performance Improvement Approach" and highlighted two of the facility's Lean Six Sigma performance improvement projects. Lean Six Sigma is the main method the facility uses to improve

performance. The first project focused on improving Code Pink, which is the response time to infant/child abduction, and the second project focused on improving the sick call process at the Fisher Clinic.

USS Red Rover

USS Red Rover is one of the facility's four branch medical clinics located on Naval Station Great Lakes. This branch medical clinic determines recruit suitability and provides recruit medical and dental in-processing for entrance into the United States Navy.

Significant accomplishments during FY 2012 were:

- Providing more than 40,000 hearing, dental, and eye examinations; 18,000 pairs of eyeglasses; and 230,000 immunizations.
- Saving $420,000 by changing the mechanism for immunization administration.
- Saving $3.7 million by eliminating unnecessary immunizations.
- Decreasing febrile respiratory infections in recruits by 75 percent by implementing the adenovirus vaccine.
- Implementing a long-acting, reversible contraceptive program for female recruits.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected PR process were reported to the PR Committee.	
X	FPPEs for newly hired LIPs complied with selected requirements.	Seventy-one profiles reviewed: • None of the FPPE results were reported to the ECOMS.
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include how the service responsible for the patient is determined, how the physician responsible for the patient is determined, or that each observation patient must have a focused goal for the period of observation.
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	The 1 month of available data reviewed: • Greater than 30 percent of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality.
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of the Blood Usage Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing and the results of inspections by government or private (peer) entities.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the results of FPPEs for newly hired LIPs are consistently reported to the ECOMS.

2. We recommended that the local observation bed policy be revised to include all required elements.

3. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed.

4. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

5. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing and the results of inspections by government or private (peer) entities.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the intensive care, the medical/surgical, the inpatient MH, and two CLC units. We also inspected the women's health, occupational therapy, physical therapy, kinesiotherapy, and primary care clinics and the emergency department. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• CLC resident weight scales and lifts and outpatient wheelchairs and scooters were not cleaned consistently.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• Gloves in all sizes and gowns were not available in the therapy clinic areas.
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that patient care equipment is consistently cleaned between patient use.

7. We recommended that processes be strengthened to ensure that gloves in all sizes and gowns are available in the therapy clinic areas.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 10 CS areas inspected during the past 6 months reviewed: • One inspector was not sufficiently rotated in inspection assignments.
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
X	The facility complied with any additional elements required by VHA or local policy.	Appointment letters and inspection documentation reviewed: • Although inspectors are limited to 3-year appointments as required by VHA policy, one inspector participated in five inspections beyond the appointment expiration date.

Recommendations

8. We recommended that processes be strengthened to ensure that inspectors are sufficiently rotated in inspection assignments and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that inspectors do not participate in inspections beyond their 3-year appointment expiration date and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • A nurse, social worker, and an administrative support person had not been dedicated to the PCCT. • VHA policy required a 0.25 FTE psychologist or other MH provider, but only a 0.1 FTE psychologist was dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 15 non-HPC staff, there was no evidence that 5 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe	
	HPC inpatients were assessed for pain with the frequency required by local policy.	

NC	Areas Reviewed (continued)	Findings
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated nurse, social worker, and administrative support person and a 0.25 FTE psychologist or other MH provider.

11. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 32 EHRs of patients enrolled in the home oxygen program (including 9 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents and 16 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 133-4A/B and CLC unit 134-3C for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• The nurse staffing methodology was not implemented until October 4, 2012.
X	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	• Unit 134-3C's average actual nursing hours per patient day were significantly below the target for the three groups of days reviewed.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that nursing managers monitor the staffing methodology that was implemented in October 2012.

13. We recommended that unit 134-3C's nurse managers reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Preventable PE

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable PE.[7]

We reviewed relevant documents and 16 EHRs of patients with confirmed diagnoses of PE[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Patients with potentially preventable PE received appropriate anticoagulation medication prior to the event.	
X	No additional quality of care issues were identified with the patients' care.	• One patient had a potentially missed PE diagnosis.
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

14. We recommended that managers initiate protected PR for the identified patient and complete any recommended review actions.

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the Pharmacy Heating, Ventilation, and Air Conditioning Renovation construction project. Additionally, we reviewed relevant documents and 25 training records (2 contractor records and 23 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • Site inspections were only conducted by the project manager and did not include all required elements.
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
X	CSC minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	• Deficiencies noted by the project manager were not documented in the minutes.
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

15. We recommended that processes be strengthened to ensure that routine construction site inspections are conducted by the required CSC members, include all required elements, and are documented.

16. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of deficiencies identified during inspections and any follow-up actions in response to unsafe conditions and that minutes track actions to completion.

Facility Profile (North Chicago/556) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	Excluded
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$382.7
Number of:	
• **Unique Patients**	47,937
• **Outpatient Visits**	363,718
• **Unique Employees[c] (as of last pay period in FY 2012)**	2,212
Type and Number of Operating Beds:	
• **Hospital**	88
• **CLC**	134
• **MH**	125
Average Daily Census: (through August 2012)	
• **Hospital**	47
• **CLC**	120
• **MH**	102
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Evanston, IL/556GA McHenry, IL/556GC Kenosha County, WI/556GD
VISN Number	12

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	72.5	62.0	61.1	58.9	67.4	58.2
VISN	68.2	66.0	59.2	59.0	57.4	59.6
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	15.2	11.0	14.8	**	27.2	19.5
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 18, 2013

From: Director, VA Great Lakes Health Care System (10N12)

Subject: **CAP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

Attached please find the Combined Assessment Program (CAP) response to the draft report from the Captain James A. Lovell Federal Health Care Center review.

I have reviewed the completed response.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans and the active duty patients and families at the Federal Health Care Center.

Jeffrey A. Murawsky, M. D.
Network Director

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 18, 2013

From: Director, Captain James A. Lovell Federal Health Care Center (556/00)

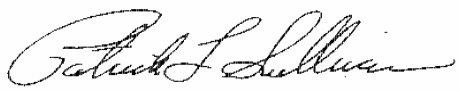
Subject: **CAP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL**

To: Director, VA Great Lakes Health Care System (10N12)

I am forwarding the Captain James A. Lovell Federal Health Care Center's response to the Office of Inspector General (OIG) Combined Assessment Program draft report.

I want to express my appreciation to the OIG Survey Team for their professional and comprehensive CAP review.

I appreciate the opportunity for this review as a continuing process to improve the care to our veterans and DoD patients.



Patrick L. Sullivan, FACHE
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the results of FPPEs for newly hired LIPs are consistently reported to the ECOMS.

Concur

Target date for completion: June 30, 2013

Facility response: All Focused Professional Practice Evaluations (FPPEs) are reported to the Executive Committee of the Medical Staff (ECOMS). A tracking system has been developed to track FPPEs from initiation to completion. ECOMS minutes will have evidence that all FPPEs for newly hired LIPs are reported to the ECOMS.

Recommendation 2. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: May 30, 2013

Facility response: The FHCC Observation Bed Policy Instruction has been rewritten. It is currently undergoing review and will be sent for signature upon completion of the review. This revision specifically specifies:

a. How the service responsible for the patient is determined.
b. How the physician responsible for the patient is determined.
c. Each observation patient must have a focused goal for the period of observation.

Recommendation 3. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed.

Concur

Target date for completion: June 30, 2013

Facility response: Our policy on admission had been to admit patients to observation if they might be discharged within 23 hours. A review of data on patients converted from observation to inpatient status and diagnoses likely to require more than 23 hours of care has been performed. Patients with diagnoses likely to require more than 23 hours

of care will be admitted on presentation. Moving forward we will continue to work on identifying and correcting systemic bottlenecks causing delay of discharge from observation and requiring conversion to inpatient care. Utilization Committee meeting minutes will show evidence of re-examination of the criteria for observation as well as analysis of proper utilization of observation by medical staff when observation to admission conversion rates exceed 30%.

Recommendation 4. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: August 31, 2013

Facility response: A process is being developed to ensure that representative samples of records from each service/program have a quality review. The sample size will be reflective of the service/program's population. The results of the quality record review will be reported to the Record of Care Committee and documented in the minutes.

Recommendation 5. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing and the results of inspections by government or private (peer) entities.

Concur

Target date for completion: August 31, 2013

Facility response: Proficiency testing is performed quarterly in blood bank (transfusion service). The results are reported to the Surgical Case Transfusion Committee and discussed, if necessary. Results are monitored monthly and will be documented in the Surgical Case Transfusion Committee minutes. Results of inspections by government or private (peer) entities will be reported to Surgical Case Transfusion Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that patient care equipment is consistently cleaned between patient use.

Concur

Target date for completion: August 31, 2013

Facility response: A plan is in place for the cleaning of inpatient and outpatient equipment (geri-chairs, wheelchairs, weight scales, lifts, and scooters) in a designated cleaning area. The Environment of Care (EOC) checklist has been updated to include cleanliness of patient care equipment. A monthly routine spot check will be conducted during EOC or nursing rounds to ensure 90% compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that gloves in all sizes and gowns are available in the therapy clinic areas.

Concur

Target date for completion: August 31, 2013

Facility response: Glove box holders have been ordered for all therapy areas. These will be installed by June 2013. Environment of Care rounds will show 90% compliance with gloves of all sizes and gowns available in therapy areas.

Recommendation 8. We recommended that processes be strengthened to ensure that inspectors are sufficiently rotated in inspection assignments and that compliance be monitored.

Concur

Target date for completion: August 31, 2013

Facility response: The tracking system has been improved to insure that the inspectors are sufficiently rotated. The schedules of the inspectors will be monitored monthly to ensure compliance.

Recommendation 9. We recommended that processes be strengthened to ensure that inspectors do not participate in inspections beyond their 3-year appointment expiration date and that compliance be monitored.

Concur

Target date for completion: August 31, 2013

Facility response: The tracking and scheduling system has been improved to prevent inspectors from performing consecutive audits in the same area and to ensure inspectors do not participate beyond their 3-year appointment. The schedules will be monitored to ensure compliance.

Recommendation 10. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated nurse, social worker, and administrative support person and a 0.25 FTE psychologist or other MH provider.

Concur

Target date for completion: Completed April 17, 2013

Facility response: A 1.0 FTE nurse practitioner, 0.25 FTE social worker, 0.25 FTE psychologist, and 0.25 FTE administrative support person have been assigned to the PCCT.

Recommendation 11. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: October 31, 2013

Facility response: The plan for end-of-life-training includes:

1. End-of-life training (general overview) is scheduled to start in May 2013 with 90% of staff completing training by September 2013.
2. End of Life Nursing Education Consortium (ELNEC) training for non-HPC staff is scheduled to start in May 2013 with a goal of 30% of staff completing training by August 2013, 90% by October 31, 2013. This training will be available online or through live presentations in order to meet the ongoing training requirements for staff.
3. Grand rounds for physicians, nurses, and other allied staff on end-of-life care will be conducted at least annually.

Recommendation 12. We recommended that nursing managers monitor the staffing methodology that was implemented in October 2012.

Concur

Target date for completion: June 30, 2013

Facility response: Each Nurse Manager is monitoring staffing on a daily basis and is reporting it monthly to the staffing methodology coordinator. Each quarter the Hospital Expert Panel comes together and reviews the staffing effectiveness for each unit and makes recommendations for any adjustments needed to maximize staffing throughout the facility. Monthly reporting will be 90% compliant.

Recommendation 13. We recommended that unit 134-3C's nurse managers reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: June 30, 2013

Facility response: Unit 134-3C staffing is being re-evaluated for a 90-day period to monitor workload and acuity of patients in an effort to possibly reset targeted Total Nursing Hours Per Patient Day (TNPPD) to maximize staffing in a safe patient centered care environment. In the interim, overtime is being used to meet the existing target of 4.5 Nursing Hours Per Patient Day.

Recommendation 14. We recommended that managers initiate protected PR for the identified patient and complete any recommended review actions.

Concur

Target date for completion: Completed February 21, 2013

Facility response: The protected PR process has been completed.

Recommendation 15. We recommended that processes be strengthened to ensure that routine construction site inspections are conducted by the required CSC members, include all required elements, and are documented.

Concur

Target date for completion: June 30, 2013

Facility response: At the Construction Safety Committee following the OIG visit, the committee established criteria for which projects would be monitored and which committee members would be conducting the surveys given the results of the Pre-Construction Risk Assessment. These surveys are documented and retained on file. The results of each are discussed during subsequent committee meetings and any follow-up actions are discussed and recommendations are made concerning long-term issues or trends. Construction Safety Committee minutes will have evidence of routine construction site inspections.

Recommendation 16. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of deficiencies identified during inspections and any follow-up actions in response to unsafe conditions and that minutes track actions to completion.

Concur

Target date for completion: June 30, 2013

Facility response: At the Construction Safety Committee following the OIG visit, the committee established criteria for which projects would be monitored and which committee members would be conducting the surveys given the results of the Pre-Construction Risk Assessment. These surveys are documented and retained on file. The results of each are discussed during subsequent committee meetings and any follow-up actions are discussed and recommendations are made concerning long-term issues or trends. Construction Safety Committee minutes will contain documentation of deficiencies identified during construction site inspections and include follow-up actions in response to unsafe conditions.

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Endnotes

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- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.

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